U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 22 May 2007

Case No. 2006-BLA-5334

In the Matter of:
R.L.G.,[1]
Claimant,

v.

PEABODY COAL COMPANY,
c/o OLD REPUBLIC INSURANCE CO.,
Employer,
and
PEABODY INVESTMENTS, INC.,,
Carrier,
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
R.L.G., Pro se
On behalf of Claimant

Richard H. Risse, Esq.
On behalf of Employer

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

[1] Effective August 1, 1006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Further, to avoid unwanted publicity of those claimants on the web, the Department has installed software that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis added*). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On January 12, 2006, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 32).[3] A formal hearing on this matter was conducted on November 17, 2006, in Zanesville, Ohio by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[4]

The issues in this case are:

1. Whether the Miner has pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank,* 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia,* that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[3] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the transcript.

[4] At the hearing, Employer withdrew the issue of whether Claimant was a miner and whether Claimant has one dependent for purpose of augmentation. (Tr. 21). Employer also withdrew the timeliness issue. (Tr. 48). Additionally, Employer listed other issues that will not be decided by the undersigned; however, they are preserved for appeal. (DX 32, Item 18).

4. Whether the Miner is totally disabled; and

5. Whether the Miner's disability is due to pneumoconiosis;

(DX 32).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

R.L.G. ("Claimant") was born on February 12, 1936, and was 70 years old at the time of the hearing. (DX 2; Tr. 23). He completed the twelfth grade. (DX 2; Tr. 23). On December 17, 1955, Claimant married D.I.M., and they remain married and living together. (DX 2; Tr. 23). He has no dependent children. (DX 2, 8; Tr. 24). Employer concedes, and I so find, that Claimant has one dependent for purposes of augmentation. (DX 32).

On his application for benefits, Claimant stated that he engaged in coal mine employment for at least 19 years. (DX 2). Claimant's last coal mine employment was as a pit mine supervisor. (DX 4; Tr. 25). Claimant described the physical requirements of the work to include standing for four hours per day and lifting 50 pounds two times per day. (DX 4).[5] Claimant stated that he retired from coal mining in 1985. (DX 2). He also noted on his application that he has not previously filed a federal pneumoconiosis disability claim. (DX 2).

Procedural History

Claimant filed a claim for benefits under the Act on February 14, 2005. (DX 2). On October 20, 2005, the District Director, Office of Workers' Compensation, issued a proposed decision and order – award of benefits and responsible operator. (DX 25). On October 26, 2005, Employer requested a revision of the Director's decision. (DX 26). The Director issued a revised proposed decision and order on November 29, 2005, and again awarded benefits. (DX 27). On December 5, 2005, Employer requested a formal hearing. (DX 29). This matter was transferred to the Office of Administrative Law Judges on January 12, 2006. (DX 32).

Length of Coal Mine Employment

On his application, Claimant stated that he engaged in coal mine employment for at least 19 years. (DX 2). The Director determined that Claimant has at least 22 years of coal mine employment. (DX 25). The parties, however, stipulated that Claimant worked at least 19 years

[5] At the hearing, Claimant testified that his last mining job at Peabody Coal Company required less physical exertion than his subsequent non-coal mining employment, and that this subsequent employment was not physical at all. (Tr. 40).

in or around one or more coal mines. (Tr. 11). I find that the record supports this stipulation, (DX 3-6), and therefore, I hold that the Claimant worked at least 19 years in or around one or more coal mines.

Claimant's last employment was in the State of Indiana (DX 3); therefore, the law of the Seventh Circuit is controlling.[6]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Peabody Coal Company as the putative responsible operator because it was the last company to employ Claimant for a full year. (DX 25). Employer does not contest its designation. (DX 32). Therefore, I find that Peabody Coal Company is properly designated as the responsible operator in this case.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant selected Dr. Paul Knight to provide his Department of Labor sponsored complete pulmonary examination. (DX 9). The examination was conducted on March 15, 2005 and the x-ray was interpreted by Dr. Muchnok on March 17, 2005. I admit the DOL sponsored evaluations under § 725.406(b). I also admit Dr. Gaziano's quality-only interpretation of the x-ray and Dr. Gerblich's validation of the ABG study under § 725.406(c).

[6] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

Claimant did not complete a Black Lung Benefits Act Evidence Summary Form. At the hearing, the Claimant submitted a group of exhibits that included the July 17, 2006 PFT and ABG studies, a February 9, 2006 letter from Dr. Basit, and treatment records. (CX 1). In addition the District Director exhibits included a number of treatment records. (DX 11). This evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit the above listed evidence.

Employer completed a Black Lung Benefits Act Evidence Summary Form. (EX 13). Employer designated Dr. Rosenberg's June 21, 2005 complete pulmonary evaluation, Dr. Wiot's interpretation of the June 21, 2005 x-ray, Dr. Renn's April 21, 2006 medical report, Dr. Wiot's July 21, 2006 CT scan interpretation, and an assortment of treatment records as initial evidence. Employer also designated Dr. Wiot's March 15, 2005 x-ray interpretation as rebuttal evidence. Finally, Employer submitted supporting depositions by Drs. Rosenberg and Renn. This evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit the above designated evidence.

X-RAYS

Exhibit	**Date of X-ray**	**Date of Reading**	**Physician / Credentials**	**Interpretation**
DX 10	3/15/05	3/17/05	Muchnok, BCR[7],B-reader[8]	2/2 sq
DX 10	3/15/05	4/11/05	Gaziano, B-reader	Quality Only
DX 22	3/15/05	5/28/05	Wiot, BCR, B-reader	2/3 ss; Type O large opacities
DX 23	6/21/05	6/21/05	Rosenberg, B-reader	2/3 st; Type O large opacities
DX 24	6/21/05	7/21/05	Wiot, BCR, B-reader	Negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height[9]**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 11 1/8/03	Good/ Good/ 1 only	66 70"	2.6 2.82*	3.93 4.28*	110	66 66*	No No*

[7] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[8] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

[9] The factfinder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find Claimant's height to be 69 inches.

EX 6 10/2/03	Not listed/ Not listed/ Only 1	67 70”	2.28 2.30*	3.73 3.64*		61.1 63.2*	No No*
DX 11 1/14/05	Not listed/ Not listed/ Only 1	68 68”	2.7	4.73	107	57	No
DX 10 3/15/05	Good/ Good/ Yes	69 68”	2.53	4.29	113	59	No
DX 23 6/21/05	Good/ Good/ Yes	69 70”	2.64 2.73*	4.19 4.32	100.5 99.2*	63.1 63.2*	No No*
CX 1 7/17/06	Good/ Good/ No	70 68.5”	2.74 2.81*	3.94 3.85*	122	70 73*	No No*

*indicates post-bronchodilator values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**
DX 11	1/08/03	29.9	68.4	Yes
DX 10	3/15/05	29.8	68.3	Yes[10]
DX 23	6/21/05	25	54	Yes
CX 1	7/17/06	28.6	66.6	Yes

* indicates post-exercise values

Narrative Reports

Dr. Paul Knight, an internist, examined Claimant on March 15, 2005 and submitted a report dated April 19, 2005. (DX 10). Dr. Knight considered the following: symptomatology (sputum, wheezing, dyspnea, cough, chest pain, orthopnea, and paroxysmal nocturnal dyspnea), employment history (19 years coal mine employment), individual history (pneumonia, chronic bronchitis, heart disease, cancer, high blood pressure, and emphysema), family history (tuberculosis, cancer, and stroke), smoking history (1 to 1 ½ packs per day, quitting in 2002), physical examination (shortness of breath, lungs were hyper resonant on percussion, and there were very distant breath sounds with a faint wheeze on auscultation), chest x-ray (emphysema, linear scars, q nodules), PFT (moderate obstruction), ABG (mild to moderate hypoxemia), and a January 15, 2005 CT scan (emphysema, bilateral lower lobe fibrosis and honeycombing). Dr. Knight diagnosed pulmonary emphysema based on an x-ray and PFT and chronic heart failure caused by multiple factors unrelated to dust exposure. He also diagnosed fibrosis and honeycombing secondary to pneumoconiosis and dust. Dr. Knight opined that Claimant was totally disabled from performing any coal mine-related work, with one-third of the impairment

[10] Dr. Gerblich, an internist and pulmonologist, validated this study. (DX 10).

due to the cardiac condition and two-thirds of the impairment caused by the respiratory condition. He also stated that this impairment diagnosis was based on the PFT, ABG and x-ray results.

Dr. Knight submitted a supplemental report dated March 23, 2005, which was attached to his April 2005 report. (DX 10). Dr. Knight stated that Claimant has an occupational lung disease caused by coal mine employment which he diagnosed by x-ray and history. In addition, he diagnosed a severe pulmonary impairment caused co-equally by his prior exposure to coal dust and tobacco. Dr. Knight opined that Claimant does not have the respiratory capacity to perform his last work as a coal miner or perform comparable work. He based this conclusion on the clinical evaluation, hypoxemia, and x-ray findings.

Dr. David Rosenberg, an internist, pulmonologist, and B-reader, examined Claimant on June 21, 2005 and submitted a report dated June 24, 2005. (DX 23). Dr. Rosenberg considered the following: the DOL sponsored evaluation, the treatment records found at DX 11**,** symptomatology (cough, wheeze, shortness of breath, and nonspecific chest pains), employment history (23 years coal mine employment, last working as a pit boss which occasionally required that he lift more than 20 pounds), individual history (currently on oxygen, cancer surgery in 1980, ventral hernia repair in 1996, and several episodes of pneumonia in 2003), smoking history (1 to 2 packs of cigarettes per day from 1954 until 2002), physical examination (no rales, rhonchi, or wheezes), chest x-ray (2/3), PFT (mild obstruction no restriction, the diffusing capacity corrected for lung volumes is severely reduced indicating there is loss of the alveolar capillary bed, air trapping is not present, MVV is mildly reduced and there was no significant bronchodilator response), ABG, an EKG (sinus tachycardia), and a CT scan (significant basilar interstitial scarring and fibrosis with honeycombing, extensive emphysema throughout the lung fields, particularly in the upper lung fields, and a small 4 mm nodule in the right upper lung zone).

Based on the evidence he considered, Dr. Rosenberg concluded that Claimant does not have clinical CWP. Despite the extensive linear lung disease identified by x-ray and CT scan, Dr. Rosenberg opined that Claimant does not have restriction due to the normal TLC and an absence of clinical findings. He explained that the linear changes at the bases are in the wrong part of the lung for CWP, but they also have the wrong configuration because CWP is a microdonular type of disease. He further explained that the markedly reduced diffusing capacity indicates a significant loss of the alveolar bed and correlates with the oxygenation abnormality and extensive linear lung disease. He concluded that Claimant's condition is consistent with asbestosis or idiopathic pulmonary fibrosis ("IPF").

From a functional perspective, Dr. Rosenberg opined that Claimant was totally disabled from performing his previous coal mine employment due to severe hypoxemia and a markedly reduced diffusing capacity. He stated that this impairment relates to linear lung disease, which is manifest by a marked decrease in diffusing capacity was out of proportion to any mild airflow obstruction seen on PFT. He opined that this could represent some form of idiopathic interstitial lung disease such as IPF. While Dr. Rosenberg noted Claimant's extensive emphysema identified by HRCT, he also emphasized that the lack of significant airflow obstruction associated with this emphysema. Dr. Rosenberg opined that absent any micronodular disease,

the emphysema must be related to Claimant's smoking history. Dr. Rosenberg summarized by stating that Claimant's diffuse linear form of interstitial lung disease, which is the primary cause of his pulmonary impairment, does not represent either clinical or legal CWP. Also, he reiterated that Claimant's emphysema was related to smoking.

Dr. Rosenberg was deposed by the Employer on August 23, 2006, when he repeated the findings of his earlier written report. (EX 8). Dr. Rosenberg explained that the ILO B-reader form is not a diagnostic tool, but simply a way to make recordings, and then you use those recordings to correlate with the clinical findings. Thus, while the ILO form he completed revealed 2/3 pneumoconiosis, he explained that this was actually unrelated to coal dust exposure, but instead, represented IPF. IPF, he continued, is of an unknown etiology but is not uncommon in middle age individuals. He explained that IPF is characterized on x-ray by linear changes in the mid to lower lung zones, and depending on its level of advancement, it can be restrictive. On the other hand, he added that pneumoconiosis is characterized by rounded opacities in the mid to upper lung zones. Dr. Rosenberg stated that these features of IPF were identified by x-ray, but he emphasized that the CT scan was essential to his determination of IPF instead of CWP. He also added that the honeycombing identified by CT scan is not a typical feature of CWP, but is instead a feature of IPF. Next, he noted that the at-rest ABG could be a feature of CWP, but based on the CT scan identified honeycombing, he found the pulmonary condition was the result of IPF. He also ruled out coal dust as a cause for Claimant's emphysema based on the CT scan findings. He added that the small nodule in the upper right lung zone might be a tumor, but that this should not be confused with progressive, massive fibrosis because it was not surrounded by areas of micronodularity.

Dr. Rosenberg submitted a supplemental report on November 13, 2006, in which he considered the exhibits Claimant submitted at the hearing. (EX 12). Based on this evidence, Dr. Rosenberg again concluded that Claimant has linear interstitial lung disease and emphysema, which he confirmed by reference to his previous CT scan. Dr. Rosenberg again opined that these conditions were unrelated to coal mine employment. In addition, he confirmed that Claimant was totally disabled from his pulmonary condition based on the existence of severe hypoxemia and a low diffusing capacity, but that this impairment was unrelated to coal mine employment. Turning to Dr. Basit's February 9, 2006 letter, Dr. Rosenberg opined that the linear densities in the mid and inferior lung zones do not relate to coal dust exposure because x-ray changes caused by coal dust manifest primarily as micronodular opacities in the upper lung zones and not in the mid and lower lung zones. He added that when the upper lobe micronodularity worsens in pneumoconiosis cases, it can spread throughout all lung zones, but not as diffuse linear opacities. He also stated that the coal mine dust related changes that Dr. Basit referred to were not confirmed by the CT scan. Furthermore, Dr. Rosebnberg opined that while Claimant has emphysema, as noted by Dr. Basit, the diffuse emphysema Dr. Rosenberg identified by CT scan is not focal emphysema associated with micronodules seen in pneumoconiosis. Thus, he concluded that this condition was related to smoking.

Dr. Jerome Wiot, a radiologist and B-reader, submitted two reports on July 21, 2005, in which he considered the June 21, 2005 x-ray and CT scan. (DX 24; EX 11). Dr. Wiot found no evidence of CWP by CT scan and concluded that the over-expansion of the lung fields was consistent with emphysema. In addition, he stated that the small nodular density in the left upper

lung field was not a manifestation of coal dust exposure, but he opined that very early bronchogenic carcinoma could not be entirely excluded. Dr. Wiot also identified basilar interstitial fibrosis with some honeycombing with associated minimal pleural reaction. While there are multiple causes of this condition, he opined that these findings in the bases do not represent CWP. He explained that CWP begins in the upper lung fields, and it is only when the disease process progresses that it moves to the mid and lower lung fields. Dr. Wiot also identified pleural changes along the lateral chest walls which could be related to pleural plaques. However, based on the scan and x-ray, he found that these changes were actually depositions of subpleural fat and not pleural plaques. Dr. Wiot concluded that the radiographic findings do not represent CWP, but are likely the result of IPF.

Dr. Abdul Basit submitted a letter on February 9, 2006. (CX 1). Based on Dr. Knight's reports and a chest x-ray conducted on March 15, 2005, Dr. Basit stated that Claimant suffers from moderate obstructive lung disease resulting in a severe respiratory impairment. He opined that this condition is the result of both tobacco use and pneumoconiosis, and is incapacitating. (CX 1).

Dr. Joseph Renn, an internist, pulmonologist, and B-reader, conducted an independent medical review and submitted a report dated April 21, 2006. (EX 1). Dr. Renn considered all of the medical evidence of record, and based on employment history (21 years coal mine employment, last working as a pit boss requiring him to lift up to 50 pounds), individual history (systematic hypertension, hyperlipidimia, lymphoma in 1980, hay fever, and renal insufficiency), family history (tuberculosis, cerebrovascular accidents, and myocardial infarction), smoking history (one to two packs of cigarettes per day for approximately 49 years, quitting in 2001), he diagnosed pulmonary emphysema from tobacco smoking and idiopathic pulmonary fibrosis which was likely the result of usual interstitial pneumonitis (UIP). Dr. Renn explained that the eleven chest radiographs of record are inconsistent with CWP because no opacities were identified in the upper lung zones. Also, since the diffusing capacity and resting hypoxemia were greater in severity than would be expected with Claimant's mild degree of obstructive airway disease, Dr. Renn opined that the pulmonary condition was the result of interstitial fibrosis and not CWP. He cited several sources to support this conclusion. Finally, Dr. Renn concluded that Claimant is totally disabled from a respiratory capacity from performing his last coal mining job as a pit boss due to the IPF.

Dr. Renn submitted a supplemental letter in which he reviewed the October 1, 2003 CT scan. (EX 2). He identified extensive, diffuse pulmonary emphysema, some of which was bullous and some that was centrilobular. He also identified honeycombing in the lung bases which he opined represented extensive interstitial fibrosis, greater in the right base. He concluded that there were no changes consistent with pneumoconiosis.

Dr. Renn was deposed by the Employer on September 14, 2006, when he repeated the findings of his earlier written report. (EX 9). In addition, he reiterated that the radiographically identified significant pulmonary emphysema in the upper zones, honeycombing, and traction bronchitis do not occur in CWP, but are consistent with IPF and bronchiectasis. Dr. Renn also found that Claimant does not have any opacities consistent with CWP such as opacities in the upper lung zones. He further explained that irregular opacities can be associated with CWP

when found throughout the lung zones, but Claimant irregular opacities have not been found throughout. Next, Dr. Renn explained that the combination of mild obstructive ventilatory defect and very severe resting hypoxemia is further suggestive of IPF and less consistent with CWP. He opined that if Claimant's severe resting hypoxemia were the result of CWP, then Claimant would have a much greater obstruction. Concerning the emphysema, Dr. Renn added that the disproportionate reduction of the volume of air flows is more typical of what would be expected in smoke-induced disease than focal emphysema related CWP.

Hospitalization Records and Treatment Notes

The record includes the following hospitalization records and treatment notes. The pertinent reports are summarized here in chronological order.[11]

May 8, 1996 – X-ray report by Dr. Chalasani: There are no pulmonary infiltrates or pleural reaction. There is minimal hyperaeration of the lungs. Bronchopulmonary markings are prominent at the bases of the lungs probably due to chronic bronchitis. Impression: Probable chronic bronchitis and hyperaeration of the lungs probably due to COPD. There is no evidence of pneumonia. (CX 1)

March 5, 2002 – X-ray report by Dr. Magness: The lungs are hyperinflated consistent with COPD and fibrocalcific changes in the lungs. There is an increase in the interstitial pattern posteriorly in the right lower lobe since the previous examination, which could represent acute superimposed pneumonic infiltrate. (EX 3)

January 7, 2003 – Examination report by Dr. Hamza: Patient is having shortness of breath that is getting worse. Lungs reveal diminished breath sounds bilaterally. Assessment: COPD. (EX 4).

January 8, 2003 – ABG study (charted above). (DX 11).

January 8, 2003 - PFT (charted above). Computerized interpretation: Possible early obstructive pulmonary impairment, severe diffusion defect, and no significant change post-bronchodilator. (DX 11).

January 8, 2003 – X-ray report by Dr. Rubenstein: Large infrahilar nodule on the right. The lung fields otherwise are essentially clear. Impression: Mild COPD. (EX 3).

January 17, 2003 – CT scan report by Dr. Dunbar: Images fail to confirm mass lesion. The prominence of the inferior lateral right hilum seems to be vascular in nature. (EX 3).

[11] Included in the treatment notes are several radiology reports. There is no evidence in the record as to the x-ray reading credentials of these physicians. §718.102(c). Also, these interpretations were all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. In addition, there is no record of the film quality for any of these x-rays. §718.102(b). Finally, the interpreting physicians did not provide an ILO classification for their readings. §718.102(b). As a result, these x-ray interpretations are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Therefore, I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).

February 20, 2003 – Examination report by Dr. Hamza: Symptoms include cough, sinus drainage, sore throat and chest congestion. Assessment: COPD and acute bronchitis. (EX 4).

April 30, 2003 – Examination report by Dr. Hamza: Patient is having shortness of breath. Lungs reveal diminished air entry. Assessment: COPD. (EX 4).

May 28, 2003 – Examination report by Dr. Hamza: Lungs reveal diminished breath sounds bilaterally. Assessment: COPD. (EX 4).

June 25, 2003 – Examination report by Dr. Hamza: Lungs are clear. Assessment: COPD. (EX 4).

August 25, 2003 – Examination report by Dr. Hamza: Lungs reveal diminished breath sounds bilaterally. Assessment: emphysema. (EX 4).

August 26, 2003 – X-ray report by Dr. Rubenstein: There is accentuated bronchial markings at both bases, which is similar to the findings on 1/8/03. The upper lung fields are clear but somewhat emphysematous. (EX 3).

September 29, 2003 – Admission report at Genesis Healthcare: Stopped smoking two years ago. Used to work in a coal mine. Lungs revealed prolonged expiration, some wheezes and rhonchi, crackles in the right base. Chest x-ray shows pulmonary infiltrates in the right. Assessment: Pneumonia, probable sepsis, significant respiratory distress.

September 29, 2003 – X-ray report by Dr. Graber: Emphysematous-appearing chest with right lower lobe infiltrate. (EX 3).

September 29, 2003 – CT scan report by Dr. Graber: No definitive evidence of pulmonary embolus. Marked COPD. Right lower lobe infiltrate. Diagnosis: COPD. (EX 3).

October 1, 2003 – CT scan report by Dr. Graber: Extensive emphysema and interstitial fibrosis with some traction bronchiectasis and honeycombing, particularly in the posterior lung bases. Diagnosis: COPD caused by infiltrate. (EX 3).

October 2, 2003 – PFT study (charted above): Moderate obstructive airway disease with poor bronchodilator response. (EX 3).

October 3, 2003 – Discharge summary by Dr. Metry: Patient presented with acute shortness of breath and has what appears to be right lower lobe pneumonia. He had COPD with exacerbation. Spirometry showed moderate obstructive airway disease and poor bronchodilator response. High resolution CT scan showed extensive emphysematous changes. Showed marked improvement with steroids, proventil, and atrovent. His lungs had prolonged expiration with no wheezes. Assessment: COPD, probable pulmonary fibrosis, O2 prescribed. (EX 6).

October 3, 2003 – Examination report by Dr. Hamza: Patient was released from the hospital and continues to feel moderate shortness of breath. Lungs reveal diminished air entry bilaterally. Assessment: COPD exacerbation and hay fever. (EX 4).

October 23, 2003 – Consultation by Dr. Basit: Lungs showed good air entry. Assessment: COPD, status post pneumonia, ex-smoker, history of lymphoma, obesity, mild renal insufficiency, and mild dyspnea. (EX 4).

November 20, 2003 – X-ray report by Dr. Rubenstein: There is rather extensive pulmonary infiltrate in the right lower lobe that was not seen on the prior study. The rest of the lung fields are clear. Impression: Infiltrate in the right lower lobe. (EX 3).

January 12, 2004 – X-ray report by Dr. Rubenstein: The lung fields are clear with slight congestion at the bases. Impression: COPD. (EX 3).

January 12, 2005 – Examination report by Dr. Hamza: Lungs reveal diminished air entry. Assessment: End stage COPD. (EX 4).

January 13, 2005 – Examination report by Dr. Basit: Patient presents with complaints of head cold, dehydration, cough, and shortness of breath. He smoked 2 ½ packs of cigarettes per day for most of his life, but has quit. His lungs revealed distant air entry. Assessment: hypertension, COPD, questionable history of CHF, history of lymphoma. (EX 5).

January 13, 2005 – X-ray report by Dr. Russ: Bilateral lower lobe predominant interstitial lung disease with right lower lobe infiltrate of uncertain chronicity. Correlation with prior studies would be useful when they become available. (EX 5).

January 13, 2005 – X-ray report by Dr. Basit: Addendum: Comparison to x-ray dated September 29, 2003 and May 18, 2001 as well as a CT scan from October 1, 2003, reveals lower lobe interstitial densities similar in appearance. No acute infiltrate is seen. (DX 11).

January 14, 2005 - PFT (charted above). Assessment: Flow volume loop, although poor quality, is not showing an obvious upper airway obstruction. Hyperinflation and air trapping and mild obstructive lung disease considered small airways type. (DX 11).

January 15, 2005 – CT scan report by Dr. Russ Edmond: Emphysematous lungs with an upper lobe predominance. Bilateral lower lobe fibrotic changes are present with honeycombing peripherally at the posterior aspect of the lung bases. There is no bronchiectasis. Small bolus lung disease is seen peripherally again, with upper lobe predominance. Impression: Upper lobe predominant emphysematous lung disease with bilateral lower lobe fibrotic changes and honeycombing; no evidence of pulmonary embolism; no significant change mildly prominent right hilar and mediastinal lymph nodes; and no significant change aneurismal and atherosclerotic descending thoracic aorta. (DX 11).

January 15, 2005 – Consultation by Dr. Basit: Patient was admitted primarily because of feeling weak. Loss of energy, feeling tired, and shortness of breath. Lungs were clear. Assessment: History of COPD, hypertension, and renal insufficiency. (EX 5).

January 15, 2005 – Examination report by Dr. Morgan: Lungs revealed scattered rhonchi in both bases. (EX 5).

January 17, 2005 – Discharge summary by Dr. Basit: Patient was admitted with increased dyspnea. CT scan of the chest showed upper lobe predominant emphysema and lower lobe fibrotic changes and honeycombing. Diagnosis: COPD, honeycombing, pulmonary fibrosis, hematuria, and diastolic dysfunction. (EX 5).

February 3, 2005 – Examination report by Dr. Hamza: Patient is short of breath chest shows distant air entry. Assessment: End stage COPD, pulmonary fibrosis and honeycombing, ex-smoker, mild renal insufficiency, history of lymphoma, diastolic dysfunction and weight gain. (DX 11).

February 3, 2005 – Examination report by Dr. Basit: Patient has shortness of breath, COPD, honeycombing pulmonary fibrosis. Lungs reveal distant air entry. Assessment: COPD, pulmonary fibrosis and honeycombing, ex-smoker, renal insufficiently, past history of lymphoma, diastolic dysfunction. (EX 4).

March 15, 2005 – PFT (charted above) (CX 1).

April 21, 2005 – Examination report by Dr. Basit: Chest is clear to auscultation. Assessment: End stage COPD, pulmonary fibrosis and honeycombing, ex-smoker, mild renal insufficiency, history of lymphoma, and mild diastolic dysfunction. (DX 11).

July 17, 2006 – PFT (charted above): Mild obstructive small airways without change after bronchodilators. Mild hyperinflation. Severe diffusion defect. (CX 1).

July 17, 2006 – ABG (charted above): Moderate pulmonary hypoxia with respiratory alkalosis. (CX 1).

July 17, 2006 – X-ray report by Dr. Wallis: Basilar bronchovascular crowding is demonstrated with interstitial predominance again seen in both lung bases. There is a similar chronic pattern. No definite superimposed acute process. (CX 1).

September 7, 2006 – Examination report by Dr. Knight: Patient has very little exertional capacity. Lungs are very distant with very poor air movement but no rales or wheezing. Assessment: COPD and hypoxemia are stable. (CX 1).

October 19, 2006 – Examination report by Dr. Knight: Chest is very distant, hyperresonant, but clear. Diagnosis: Severe COPD, CWP, and severe hypoxemia. (CX 1).

Smoking History

Claimant testified that he smoked from 1955 until 2002 at a rate of 2 to 2 ½ packs per day. (Tr. 29-30). However, based on his wife's testimony, it is not clear whether Claimant actually smoked as much as he conceded. In addition, Claimant responded to Employer's interrogatories by stating that he smoked 1 to 1 ½ packs per day ending in 2002. (EX 10). Dr. Knight reported a smoking history of 1 to 1 ½ packs per day, quitting in 2002. (DX 10). Dr. Rosenberg reported smoking history 1 to 2 packs of cigarettes per day from 1954 until 2002. (DX 23). I find that the amounts Claimant reported to the physicians is generally consistent with his interrogatory responses. Therefore, I find that Claimant smoked for approximately 47 years at an average of 1 ½ packs per day, or 70 ½ pack-years, but that he quit smoking in 2002.

DISCUSSION AND APPLICABLE LAW

This claim was filed after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

   (iii) Is totally disabled (see § 718.204(c)), and

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

(1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). I may also assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989). In *Roberts v. Bethlehem Mines Corp*., 8 B.L.R. 1-211, 1-213 n. 5 (1985), however, the Board stated that it "takes official notice that the qualifications of a certified radiologist are at least comparable if not superior to a physician certified as a reader pursuant to 42 C.F.R. § 37.51 …." Finally, an administrative law judge may consider a physician's x-ray interpretation positive for pneumoconiosis pursuant to § 718.202(a)(1) without considering the doctor's comment. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.)(the Board held that the interpreting physician's comment that the Category 1 opacities found on the chest x-ray was not coal workers' pneumoconiosis did not affect his diagnosis of the disease under §718.202(a)(1), "but merely addresses the source of the diagnosed pneumoconiosis").

The record contains four interpretations of two chest x-rays, and one quality-only interpretations. Drs. Muchnok and Wiot, both radiologists and B-readers, interpreted the March 15, 2005 x-ray as positive for pneumoconiosis. There were no negative readings. Therefore, I find this film to be positive.

Dr. Rosenberg, a B-reader, read the June 21, 2005 film as positive for pneumoconiosis. Dr. Wiot, however, interpreted the film as negative. Therefore, according more weight to Dr. Wiot's superior credentials, I find that the June 21, 2005 film is negative for pneumoconiosis.

I have determined that the March 15, 2005 x-ray is positive for pneumoconiosis and the June 21, 2005 film is negative. The June film is more recent than the March film. However, I do not find three months to be a sufficient passage of time to accord greater weight to the subsequent interpretation. Three of the four interpretations were positive for pneumoconiosis, and two of the three dually credentialed readings found Claimant to suffer from at least 2/2 pneumoconiosis. In fact, Dr. Wiot offered the only negative interpretation of record, and he provided no explanation as to why his interpretation from two months prior reflected 2/3 pneumoconiosis. Therefore, I accord his opinion less weight than I do the opinion by Dr. Muchnok. As a result, I find that Dr. Muchnok's x-ray interpretation is the most probative, and thus, I find that the preponderance of the x-ray evidence is positive for pneumoconiosis under subsection (a)(1).[12]

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has not established the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

[12] I note that under the direction of *Cranor* cited *infra*, I have declined to consider the narratives accompanying these x-rays under subsection (a)(1).

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also*, *Mosely v. Peabody Coal Co,.* 769 F.2d 257 (6th Cir. 1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860.

Dr. Knight, an internist, considered PFT and ABG studies, smoking and coal mine employment histories, a physical examination, an x-ray, and a CT scan. Dr. Knight diagnosed emphysema secondary to factors unrelated to dust exposure, and fibrosis and honeycombing secondary to pneumoconiosis and dust exposure. I find that the objective evidence he considered, namely the CT scan, adequately supports his opinions. Therefore, I find Dr. Knight's opinion to be well-reasoned and documented, and accord it probative weight as positive for pneumoconiosis.

Dr. Rosenberg, an internist and pulmonologist, considered accurate employment history, smoking history, PFT and ABG studies, a physical examination, an x-ray, and a CT scan. Pursuant to § 718.107, only one interpretation of each CT scan is permissible as affirmative evidence. *Webber v. Peabody Coal Co,* 23 B.L.R. 1-123 (2006)(en banc). Employer, however, submitted both Dr. Rosenberg's and Dr. Wiot's interpretations of the June 21, 2005 CT scan.

In *Harris v. Old Ben Coal Co*., 23 B.L.R. 1-98 (2006)(en banc)(J. McGranery and J. Hall, concurring and dissenting), a case arising under the amended regulations in the Seventh Circuit, the Board held that a physician's medical opinion must be based on evidence that is admitted into the record in accordance with 20 C.F.R. § 725.414. In this vein, the Board concluded that the Seventh Circuit's decision in *Peabody Coal Co. v. Durbin*, 165 F.3d 1126 (7th Cir. 1999), was not applicable to a claim filed under the amended regulations. In *Durbin*, the Seventh Circuit held that a medical opinion could be fully credited even if the physician refers to evidence that is not in the record. Because *Durbin* was decided prior to promulgation of the amended regulations, the Board concluded that it is not controlling. Rather, the Board stated that "[w]ithin this new regulatory framework, requiring an administrative law judge to fully credit an expert opinion based upon inadmissible evidence could allow the parties to evade both the letter and the spirit of the new regulations by submitting medical reports in which the physicians have reviewed evidence in excess of the evidentiary limitations."

Importantly, the Board held that "an administrative law judge is granted broad discretion in resolving procedural issues, particularly where the statute and the regulations do not provide explicit guidance as to the sanction that should result when the requirements of a regulation are not satisfied."

The Board noted here, when an Administrative Law Judge is confronted with an opinion that considers evidence not admitted into the formal record, he or she may exclude the report, redact the objectionable content, ask the physicians to submit revised reports, or consider the physicians' reliance on inadmissible evidence in deciding the probative value to accord their opinions.

Here, Employer specifically designated Dr. Wiot's interpretation as affirmative CT scan evidence. Dr. Rosenberg's conclusions are inextricably tied to the CT scan he considered.[13] Therefore, I find that Dr. Rosenberg's interpretation and all of his conclusions that rely on this study are inadmissible according to the Board's interpretation of §718.107.

Dr. Rosenberg stated in his deposition that the CT scan was essential to his determination of IPF instead of CWP. Specifically, he opined that the honeycombing identified by CT scan was not a feature typical to CWP. Also, while the ABG study demonstrated features that could be typical of CWP, based on the CT scan results, he was able to rule out dust exposure as a cause. In addition, even his emphysema diagnosis was based on his interpretation of the CT scan. Therefore, upon review of Dr. Rosenberg's narrative reports and his deposition testimony, I find that his conclusions as to whether Claimant has pneumoconiosis are inseparable from his reliance on the CT scan he considered. Thus, Dr. Rosenberg's medical opinions will be given no weight in the analysis under subsection (a)(4).

Dr. Wiot, a radiologist and B-reader, interpreted the June 21, 2005 x-ray and CT scan. He opined that the CT scan showed no evidence of CWP, but instead, revealed basilar interstitial fibrosis and honeycombing associated with minimal pleural reaction. While he was unable to identify a cause for this condition, he emphasized that due to their location they were not the result of coal dust exposure. I find that the objective evidence Dr. Wiot considered adequately supports his opinion. Therefore, bolstered by his advanced credentials, I find that his opinion is well-reasoned and well-documented, and accord it substantial probative weight.

Dr. Basit considered Dr. Knight's report and a chest x-ray, and concluded that Claimant's moderate obstructive lung disease was partially the result of pneumoconiosis. In addition, I note that the treatment records include seven entries by Dr. Basit. In none of these notes did he mention the existence of pneumoconiosis, but instead, without discussion of cause, he repeatedly diagnoses COPD and other pulmonary conditions. Despite these inconsistencies, as I have found that Dr. Knight's report was adequately supported by the objective evidence, and as Dr. Basit based his opinion on this report, I similarly find Dr. Basit's conclusion to be well-reasoned and well-documented. Therefore, I accord Dr. Basit's opinion some probative weight.

[13] I note that under *Harris*, the exclusion of a report is a last resort. Here, because Dr. Rosenberg's conclusions are inseparable from the CT scan – the consideration of the report would in essence allow the Employer to submit an additional CT scan through the "backdoor." As such, I find no other option other than giving this report no weight.

Dr. Renn, an internist, pulmonologist, and B-reader, performed an extensive medical evidence review in which he considered all of the evidence of record. Furthermore, he separately interpreted the October 1, 2003 CT scan that was included in the treatment records. Dr. Renn concluded that Claimant suffered from pulmonary emphysema from tobacco smoking and IPF. While he was unable to identify the etiology of the IPF, between his reports and deposition, he provided a thorough explanation as to why he did not find this condition to be related to coal dust exposure. I find that the objective evidence Dr. Renn considered, namely the x-ray evidence in conjunction with the PFT and ABG studies, adequately supports his opinion. Therefore, bolstered by his advanced credentials, I find Dr. Renn's opinion to be well-reasoned and well-documented, and accord it substantial probative weight.

The evidentiary record contains four reasoned narrative medical opinions. While all four of these physicians diagnosed emphysema, none concluded that this condition was a result of coal dust exposure. Therefore, I find that Claimant does not suffer from legal pneumoconiosis.

Drs. Basit and Knight opined that Claimant suffers from clinical pneumoconiosis. On the other hand, Drs. Wiot and Renn opined that Claimant's pulmonary condition was the result of IPF. I note that Dr. Basit's opinion was based primarily on Dr. Knight's opinion, and Dr. Knight's opinion was based almost exclusively on the CT scan interpretation. While I have accorded their opinions probative weight, I also note that Dr. Wiot found a subsequent study not to reveal the existence of CWP. Thus, based on his superior credentials and his more detailed explanation of his reason for excluding coal dust as a cause for the condition, I accorded his opinion more weight than those by Drs. Basit and Knight. Furthermore, I have accorded Dr. Renn's highly credentialed and well-reasoned opinion substantial probative weight. Dr. Renn very effectively explained how the PFT, ABG, and examination evidence supported the conclusion that Claimant's pulmonary condition was the result of IPF and was unrelated to coal dust exposure.

Considering all of the medical opinion evidence under subsection (a)(4), I find that the well-reasoned and documented opinion by Dr. Renn, supported by Dr. Wiot's radiographic interpretations and conclusions, is entitled to more weight than the reasoned and documented opinions of Drs. Basit and Knight. Therefore, I find that Claimant has not proven the existence of clinical pneumoconiosis by a preponderance of the evidence under subsection (a)(4).

Claimant has not established the presence of pneumoconiosis under subsection (a)(2)-(4). However, he has successfully proven that he suffers from clinical pneumoconiosis under subsection (a)(1). Therefore, I find that Claimant has proven the existence of pneumoconiosis under §718.202 (a)

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must also prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* I

have found that Claimant has established 19 years of coal mine employment. Therefore the presumption of §718.203(a) is triggered. The Employer now has the burden to rebut this presumption.

I have found that the x-ray evidence considered under §718.202 (a)(1) was sufficient to prove the existence of pneumoconiosis. I note, however, that while Drs. Wiot and Rosenberg's ILO B-reader forms identified 2/3 pneumoconiosis, both of these physicians included narrative descriptions stating that the actual finding did not represent pneumoconiosis. At the deposition, Dr. Rosenberg explained that the ILO B-reader form is not a diagnostic tool, but simply a way to make recordings that must be correlated with the clinical findings. Thus, while the ILO form he completed reflects 2/3 pneumoconiosis, he explained that the findings were unrelated to CWP, but, in fact, represented IPF. Similarly, Dr. Wiot concluded that while his ILO form of the March 15, 2005 x-ray showed 2/3 pneumoconiosis, he concluded that the findings were not those of CWP, but actually indicated asbestosis. Furthermore, in Dr. Wiot's subsequent interpretation of the June 21, 2005 x-ray, supported by his interpretation of a CT scan, he found that Claimant suffered from IPF and not CWP.

Considering Dr. Wiot's and Dr. Rosenberg's narrative explanations of their x-ray findings, it is apparent that according to the ILO form, they technically identified pneumoconiosis, but that neither of these physicians concluded that the pulmonary condition arose from Claimant's coal mine employment. As a result, only Dr. Muchnok's dually credentialed interpretation of an x-ray, which was silent as to whether the pneumoconiosis arose out of coal mine employment, is the only x-ray interpretation that conceivably supports a finding of CWP arising from coal mine employment. Furthermore, I have found that the preponderance of the medical reports under §718.202 (a)(4), including the CT scan evidence, do not support a finding that Claimant's suffers from clinical or legal pneumoconiosis which arose from coal mine employment.

Considering all of the evidence of record, I find that Dr. Wiot's two x-ray interpretations and his CT scan interpretation, supported by Dr. Renn's medical evidence review, are the most probative as to whether Claimant's pneumoconiosis arose out of coal mine employment, and thus, I accord them the most weight. Therefore, I find that Employer has successfully rebutted the presumption § 718.203(a). Furthermore, Dr. Muchnok provided no discussion as to whether the pneumoconiosis he identified on the ILO B-reader form arose from coal mine employment. Also, Drs. Basit and Knight provided no explanation as to why the bilateral lobe fibrosis and honeycombing represented pneumoconiosis arising out of coal mine employment as opposed to IPF from an unknown source. As a result, I find that their opinions are insufficient to prove that Claimant's pneumoconiosis arose out of coal mine employment. Therefore, I find that Claimant has not proven that his clinical pneumoconiosis arose from coal mine employment.

Total Disability

To be entitled to benefits under the Act, Claimant must also demonstrate that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under Section 718.204(b), all relevant probative evidence,

both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

I have determined that Claimant has not established that he suffers from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. There are no PFT values equal to or below those found in Appendix B of Part 718. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of arterial blood gas studies meet the requirements listed in the tables found at Appendix C to Part 718. All of the ABG evidence of record produced values that meet the requirements of the tables found at Appendix C to Part 718. Therefore, I find that Claimant has established total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has not established the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment.

In assessing total disability, the administrative law judge is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

Claimant's usual coal mine employment as a pit boss involved standing for four hours per day and lifting 50 pounds two times per day. (DX 4). Every physician of record who offered an opinion as to the capacity to perform previous coal mine employment found that Claimant was totally disabled. These opinions are supported by the PFT and ABG evidence that each physician considered. I find that the total pulmonary disability conclusions by Drs. Knight, Basit, Rosenberg, and Renn are adequately supported by the evidence, and thus, are well-reasoned and documented. Therefore, I find that Claimant has proven by a preponderance of the evidence that he is totally disabled under § 718.204(b)(2)(iv).

Claimant has not established that he is totally disabled under subsection (b)(2)(i) or (iii), but has conclusively proven total disability under subsection (b)(2)(ii) and (iv). Upon weighing all evidence concerning total disability under §718.204 (b)(2), I find that the qualifying ABG results, supported by the narrative medical opinions, are the most probative. Therefore, I find that Claimant has established that he is totally disabled from a pulmonary or respiratory standpoint from performing his last coal mining job.

Total Disability Due to Pneumoconiosis

The amended regulations at § 718.204(c) contain the standard for determining whether a miner's total disability was caused by a miner's pneumoconiosis. Section 718.204(c)(1) determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in § 718.305 and § 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis. Except as provided by § 718.204(d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. § 718.204(c)(2).

Drs. Knight, Basit, Rosenberg, and Renn all opined that Claimant was totally disabled from a pulmonary prospective. Drs. Knight and Basit concluded that this disability was due, at least in part, to clinical pneumoconiosis. Dr. Rosenberg concluded that Claimant was totally disabled, in part, due to his IPF. Similarly, Dr. Renn concluded that Claimant was totally disabled due to his IPF. I find that all of these opinions are adequately based on the evidence considered, and thus, are well-reasoned and documented. Furthermore, in the analysis under § 718.202(a)(1), I found that the IPF identified by x-ray technically constitutes pneumoconiosis. Therefore, since every physician to offer an opinion as to the cause of Claimant's total pulmonary disability concluded that this condition was due to IPF or pneumoconiosis, I find that Claimant has proven by a preponderance of the evidence that his total disability is due to pneumoconiosis.

However, since I have also found that Claimant's pneumoconiosis does not arise out of coal mine employment, I must therefore deny the claim.

Entitlement

Claimant has established that he is totally disabled due to pneumoconiosis, but he has not established that his pneumoconiosis arose out of coal mine employment. Therefore, Claimant is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of R.L.G. for benefits under the Act is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).